

## FACILITIES DEVELOPMENT DIVISION ~

Phone (916) 654-3362 FAX (916) 654-2973  
Phone (916) 324-9090 FAX (916) 324-9145 North and Central Region  
Phone (213) 897-0166 FAX (213) 897-0168



A	Name of Facility:				OFFICE USE ONLY		
	Address - Street:		Phone:		OSHPD #:		
			FAX #:				
	City:		County:		Zip:		
	Administrator:		Phone:		Facility I.D. #:		
		FAX #:					
		E-mail:					
Scope of Project (45 characters max):		Applicant Job #:					
B	Description of Project:				<input type="checkbox"/> Geotech Only		
					<input type="checkbox"/> Preliminary		
					<input type="checkbox"/> Final		
					<input type="checkbox"/> SB 1953 Mitigation Construction Project (Complete "J")		
	Total Beds						
Before Construction:				After Construction:			
C	Kind of Project:				<input type="checkbox"/> New Facility (N)		
					<input type="checkbox"/> Addition (A)		
				<input type="checkbox"/> Remodel (R)			
Type of Facility:				<input type="checkbox"/> General Acute Care			
				<input type="checkbox"/> Skilled Nursing (SNF) and Interim Care Facility (ICF)			
				<input type="checkbox"/> Psychiatric Hospital			
				<input type="checkbox"/> Correctional Treatment Center (CTC)			
				<input type="checkbox"/> Clinic			
D	Legal Owner:		Phone:				
			FAX #:				
			E-mail:				
	Address:		City:		State: Zip:		
E	ESTIMATED COSTS					OSHPD RECEIPT STAMP	
	1. Estimated construction cost of project (Including Fixed Equipment, <u>excluding</u> Radiology Equipment, Design Fees, Inspection Fees, and Off Site work) .....\$ _____						
	2. Estimated cost of Radiology Equipment (X-ray, MRI, CT Scans, etc) .....\$ _____						
	<u>FEES WILL BE BASED UPON:</u> <u>Skilled Nursing Facilities (SNF) are 1.5% (.015) of estimated cost</u> <u>Acute Care Hospitals (Hosp) fees are 1.64% (.0164) of estimated cost</u>						
F	Application for Plan Review made by (Name typed):						
	Signature:		Date:				
	Title:		Phone #:				
	Address:		FAX #:				
	City:		State:		Zip:		
	E-mail:						
	Who is to be known as: <input type="checkbox"/> Legal Owner/Administrator						
<input type="checkbox"/> Agent for the Legal Owner/Administrator (Authorization must be attached)							
G	Enclosed with this application are the following documents:						
	_____ Plans		_____ Geotechnical Reports (For New Facilities and Additions) Date sent: _____				
	_____ Specifications		_____ Testing, Inspection and Observation Program (TIO)				
	_____ Structural Calculations		_____ Verification of conformance to Local Codes (for New Facilities and Additions)				
	_____ Equipment Anchorage Calculations		_____				
	_____ Design Program (Optional)		_____				

**OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT****FACILITIES DEVELOPMENT DIVISION ~**1600 9<sup>th</sup> Street, Room 420 ~ Sacramento, California 958141831 9<sup>th</sup> Street ~ Sacramento, California 95814

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**Application for Plan Review**

<b>H</b>	Name of Facility (from front page)			OSHPD #
<b>I</b>	<b>Plans and Specifications prepared by the following:</b> <span style="float: right;"><b>Check discipline in general responsible charge of project</b> <input checked="" type="checkbox"/></span>			
	Architect – Firm <span style="float: right;"><input type="checkbox"/></span>			
	Individual Responsible:		E-mail:	Lic. #:
	Alternate:		E-mail:	Lic. #:
	Address:		Phone #:	
	City:	State:	Zip:	FAX #:
	Structural Engineer – Firm <span style="float: right;"><input type="checkbox"/></span>			
	Individual Responsible:		E-mail:	Lic. #:
	Alternate:		E-mail:	Lic. #:
	Address:		Phone #:	
	City:	State:	Zip:	FAX #:
	Mechanical Engineer – Firm <span style="float: right;"><input type="checkbox"/></span>			
	Individual Responsible:		E-mail:	Lic. #:
	Alternate:		E-mail:	Lic. #:
	Address:		Phone #:	
	City:	State:	Zip:	FAX #:
	Electrical Engineer – Firm <span style="float: right;"><input type="checkbox"/></span>			
	Individual Responsible:		E-mail:	Lic. #:
	Alternate:		E-mail:	Lic. #:
	Address:		Phone #:	
	City:	State:	Zip:	FAX #:
	Geotechnical Report – Firm <span style="float: right;"><input type="checkbox"/></span>			
	Individual Responsible:		E-mail:	Lic. #:
	Alternate:		E-mail:	Lic. #:
	Address:		Phone #:	
	City:	State:	Zip:	FAX #:
	Contractor – Firm <span style="float: right;"><input type="checkbox"/></span>			
	Individual Responsible:		E-mail:	Lic. #:
	Alternate:		E-mail:	Lic. #:
	Address:		Phone #:	
	City:	State:	Zip:	FAX #:

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**Application for Plan Review****SB 1953- Mitigation Construction Projects**

<b>J</b>		<b>OFFICE USE ONLY</b>
<b>Facility #</b> _____ <b>Bldg. #</b> _____ <b>Bldg. Name</b> _____  <b>Deficiencies Mitigated</b> <div style="border: 1px solid black; height: 100px; width: 100%;"></div>		<b>OSHDP #:</b> _____  <b>Region:</b> _____ <b>Field Review (FR) Staff:</b> _____ <b>Plan Review (PR) Staff:</b> _____  <b>Date:</b> _____
<b>SPC From</b> _____ <b>SPC To</b> _____ <b>SPC Partial/Full</b> _____ <b>NPC From</b> _____ <b>NPC To</b> _____ <b>NPC Partial/Full</b> _____		
<b>Facility #</b> _____ <b>Bldg. #</b> _____ <b>Bldg. Name</b> _____  <b>Deficiencies Mitigated</b> <div style="border: 1px solid black; height: 100px; width: 100%;"></div>		
<b>SPC From</b> _____ <b>SPC To</b> _____ <b>SPC Partial/Full</b> _____ <b>NPC From</b> _____ <b>NPC To</b> _____ <b>NPC Partial/Full</b> _____		
<b>Facility #</b> _____ <b>Bldg. #</b> _____ <b>Bldg. Name</b> _____  <b>Deficiencies Mitigated</b> <div style="border: 1px solid black; height: 100px; width: 100%;"></div>		
<b>SPC From</b> _____ <b>SPC To</b> _____ <b>SPC Partial/Full</b> _____ <b>NPC From</b> _____ <b>NPC To</b> _____ <b>NPC Partial/Full</b> _____		

(Please, duplicate page "J" for more buildings.)

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## INSTRUCTIONS FOR APPLICATION FOR PLAN REVIEW (OSH-FD-121)

Do not write in Office Use Only area on this application.

Note: If licensure by the California Department of Health Services is not required by your facility, review by OSHPD is not required and the application is not required. Your application and plans should be submitted to local jurisdictions.

- A Enter name as it appears on the facility license. Enter street address, city, county, and zip code (five or nine digit zip code as applicable). Enter name of administrator, phone number, fax number, and e-mail address.

Scope of project - enter a brief (45 characters max) description statement of the work to be performed. Applicant jobs number - if the facility or architect has a numbering system for projects, enter that project number.

- B Description of Project - Check whether this application accompanies a geotechnical report, preliminary report, or final plan submittal. Describe the work to be performed. Where appropriate, include square footage and quantities. Enter total bed count before construction and after construction.

- C Check the kind of project. Check Type of Facility as licensed.

- D Enter the name of the legal owner, address, phone, fax number, e-mail address, and street address.

- E Estimated Cost

Line 1. Enter estimated construction cost of project, including Fixed Equipment to be permanently attached to the building either electrically, mechanically or structurally, but excluding all design fees, inspection fees, off-site work and radiology equipment cost.

Line 2. Estimated cost of radiology equipment. (X-ray, MRI, CT Scans, etc.)

- F This application for plan review is to be signed and dated by the legal owner or administrator of the facility or agent. If signed by the agent of the legal owner or administrator, the authorization shall be attached to this application. Indicate in the appropriate boxes the name, signature, date, title, address, phone number, fax number, city, state, zip code, and e-mail address of the applicant.

- G Indicate the number of documents enclosed.

- Plans and Specifications - Submit one (1) set of plans and specifications for projects involving the structural frame of a health facility.

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- Submit one (1) set of plans and specifications for nonstructural health facility projects or for one story, type five skilled nursing facilities.
- Submit copies of structural calculations and equipment anchorage calculations.
- The applicant may submit a copy of the design program if desired.
- Submit three (3) sets of geotechnical reports for projects involving new facilities and additions to existing facilities. If geotechnical reports were previously submitted to OSHPD, indicate the date they were sent.
- Testing, Inspection, and Observation Program (TIO)
- If verification of conformance to local is required, indicate that these are being included with the application.
- Spaces are provided for additional information or documents being enclosed with the application.

H Enter the name of the facility from Section A on Page 1.

I Provide information for those disciplines which are involved in this project. Check the box for the discipline, which is in general responsible charge of this project. For each discipline, provide the name of the individual in responsible charge of the project, e-mail address, his/her license number, an alternate person to contact, e-mail address, his/her license number, the street address, phone and fax number, city, state, and zip code.

J Provide the following information for each building in this SB 1953 Mitigation Construction Project:

- Building name and number.
- Deficiencies mitigated by this project.
- SPC before and after construction; Partial or full Compliance.
- NPC before and after construction; Partial or full Compliance.

Full Compliance should only be chosen if this SB 1953 Mitigation Construction Project meets all requirements for SPC/NPC compliance for the listed Building as designated in the Compliance Plan.